

Blood-Stream Infection (CDC)

From: hud7800@aol.com
Sent: Thursday, November 19, 2009 3:23 PM
To: Blood-Stream Infection (CDC)
Cc: HUD7800
Subject: CDC Public Comment

Attachments: APIC poster.pdf; IHI BSI Poster.pdf; AVA poster.pdf; 2006 INS STANDARDS FOR SKIN ANTISEPSIS.pdf; Strategies to Prevent CVL BSIs in Acute Care Hospitals.pdf; Clinical Practice Guidelines for the Diagnosis and Management of Intravascular Catheter-Related Infection-2009 Update by IDSA.pdf



APIC poster.pdf
(221 KB)



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(1 MB)



AVA poster.pdf
(179 KB)



2006 INS
STANDARDS FOR SKIN ANTISEPSIS



Strategies to
Prevent CVL BSIs in Acute Care Hospitals



Clinical Practice
Guidelines for the
Diagnosis and Management of
Intravascular Catheter-Related
Infection-2009 Update by IDSA

Dear HICPAC

Committee:

My name is John H. Garrett Jr, and I am an Infection Preventionist based in Atlanta, GA. Thank you for the opportunity to provide comment back for consideration of this much needed revision of the guidelines. In response to your request for public comment for the currently proposed Draft Guidelines for the Prevention of Intravascular Catheter Related Infections, I would like to offer my support of a change in the verbiage of the recommendation specifically for skin antiseptics.

Currently the draft guideline calls for a 2% Chlorhexidine based skin antiseptic solution to be used for central venous catheter insertion. The current Infusion Nurse's Society Standards for Care (INS), the Society for Healthcare Epidemiology of America (SHEA), and the Infectious Diseases Society of America (IDSA) all have released recent guidelines that support the use of an alcoholic chlorhexidine solution containing a concentration of chlorhexidine gluconate (CHG) greater than 0.5% CHG, not the exclusive 2% that is referred to in the current Draft CDC document. The current draft CDC document does not call for an alcoholic CHG solution, and only makes reference to a 2% CHG solution. The specific study referenced used an aqueous solution of CHG. The synergistic effects of CHG and isopropyl alcohol are key to providing initial skin antiseptics and also persistent activity of CHG on the patient's skin. Use of an aqueous based CHG solution alone would not provide adequate initial skin antiseptics. I would urge the HICPAC committee to make a more inclusive recommendation that is in line with the current standards of other Infection Prevention organizations and change the guidelines verbiage to read "use an alcoholic Chlorhexidine gluconate solution greater than 0.5% CHG." This would minimize confusion amongst clinicians, and offer all patients the benefits of Chlorhexidine gluconate.

Additionally, the recommendation for use of CHG for insertion of peripheral intravenous catheters has been changed to isopropyl alcohol, which creates two standards of care for our patients. We would like one standard for care for our patients for all vascular access procedures. I would strongly urge the HICPAC committee to evaluate this request to be inclusive of all CHG containing skin antiseptics available under the formal approval of the Food and Drug Administration.

Finally, I would also appreciate the recommendation regarding the cleaning of ports and hubs with either alcoholic Chlorhexidine (CHG preferred) or 70% isopropyl alcohol to be consistent with that of other organizations such as SHEA. Therefore, my recommendation would be to word this particular piece as "before accessing catheter hubs or injection ports, clean them with an alcoholic chlorhexidine preparation or 70% alcohol to reduce contamination." This will give clarity to clinicians about the appropriate cleaning of these devices that serve as sources for contamination.

Thank you for your consideration. If you have any questions, please feel free to contact me directly using the contact information below:

Best regards

John H. Garrett Jr, PhD, MSN, MPH

Chair, Building a Better Bundle Committee Association for Vascular Access Board of
Directors, Vascular Access Certification Corporation Infection Preventionist

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